State of Maine

Department of Health & Human Services (DHHS)

MaineCare

Medicaid Management Information Systems

Maine Integrated Health Management Solution
Dental Services Billing Instructions Guide

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Version	Date	Author	Action/Summary of Changes	Status
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0.2	12/03/09— 12/09/09	K. Goldhammer / S. Savage / C. Coulombe / L. Osgood / S. Mackneer	Response to State comments received 12/3 / Quality Assurance	Draft
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0.5	01/05/2010	RJ Roy / M Smith	Reversed the change to add slashes to dates. Added edits recommended by Unisys configuration and claims staff.	Draft
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1.0	01/11/2010	M Smith	Changes accepted and made final.	Final

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Table of Contents

1. Introduction

This document provides billing instructions for dental services provided to MaineCare members when submitting claims for processing in the Maine Integrated Health Management Solution (MIHMS). As alternatives to paper, providers are encouraged to submit claims using the HIPAA compliant Electronic Data Interchange (EDI) 837D format, or by Direct Data Entry (DDE), which is an online process where data is directly entered into MIHMS for processing and payment. These paper alternatives provide countless efficiencies for claims processing without the traditional problems associated with the submission of paper claims; such as getting lost in the mail, data entry errors, delayed adjudication, etc. Providers electing to use DDE or EDI must register as a Trading Partner after successful enrollment in MaineCare.

Providers are encouraged to use these paper alternatives and may reach out for support by calling customer support. A phone number will be published nearer to the Go Live date.

- Direct Data Entry is a new option for MaineCare providers that will work well for providers who would like to submit Claims, Authorizations, and Referrals directly into MIHMS. These functions can be done one at a time, or set up using rosters to make the entry easier.
- Providers may also submit batch transaction files in the HIPAA compliant X12 EDI format.
- Additional information can be found for these billing options at the MIHMS website at: https://mainecare.maine.gov/.

The instructions contained in this document are to be followed for completing the claim form for the submitted dates of service to include April 1, 2010 forward. Service dates prior to April 1, 2010 will be not be processed by MIHMS, but will follow different billing instructions as specified in the MECMS billing requirements posted at http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html. Providers should use caution when billing for services with dates starting with April 1, 2010 and forward as the instructions will be substantially different than the aforementioned MECMS instructions.

Each provider is responsible for obtaining their own ADA 2006 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

Pre-printed ADA 2006 forms may be purchased pre-printed (laser-cut or continuous feed), or virtual forms may be purchased in the form of software. Forms may be purchased at office supply centers, or from other sources including:

http://www.claimformsplus.com/catalog/2006-ada-dental-claim-forms.html

https://siebel.ada.org/ecustomer_enu/start.swe?SWECmd=Start&SWEHo=siebel.ada.org

DHHS does not recommend or endorse any particular supplier of forms.

In addition to implementation of MIHMS, a HIPAA compliant claims processing system, a series of related business initiative projects have also been completed. Concurrent business process changes and regulatory compliance efforts which will also affect billing include:

- Achieving HIPAA compliance
  - Eliminating the use of local codes
  - Provider re-enrollment with use of the NPI
- Examination of options for more consistent and useful pricing structures for long-term care facilities
- Review of member rates

- Design of member benefit packages

Additional information regarding these changes can be found at: http://www.maine.gov/dhhs/oms/fiscal_agent_project_index.html, and in a separate Transition Guide to be published soon.

General Guidance on Submitting Claims

1. Billing instructions are intended to assist providers with the preparation of claims, and are intended to supplement the guidance provided in the applicable MaineCare Policy. Policies may be accessed at the following website:

   http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html

2. Claims will be returned to the Provider for any of the following reasons:
   - Not on an original Claim Form
   - The form is incorrect, not legible, print is too light, and/or the alignment is not correct
   - Claim is damaged
   - Claim is completed with red ink
   - An attachment
     i Is not 8 ½ x 11
     ii Has double sided content
   - If any required fields are missing as shown in the table below
   - Federal Tax ID is less than 9 digits
     - Patient's First and/or Last name are missing
     - Patient's Date of Birth is missing or not in MMDDCCYY format
     - Claim does not have at least one line of detail in lines 1-10
     - NPI is less than 10 digits
     - If Insured's ID # is not in one of these four valid formats:
       i Eight digits followed by A,
       ii Eight digits followed by T,
       iii Six digits preceded by T, or
       iv Six digits followed by T
     - Signature (typed or stamped is acceptable) and/or date is missing.

1. Codes

Use current American Dental Association (ADA)-approved codes for dental procedures from the Current Dental Terminology Manual (CDT).

Use the Procedure Codes in Chapter III of the MaineCare Benefits Manual policy section for which the billing is being performed. Access to these codes can be found at the following website: http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html

2. Dates

The required format for all date fields is eight digits (MMDDCCYY). (Example: October 1, 1979 = 10011979)

3. Monetary amounts
    - The format is dollars, decimal point, cents, with no dollar signs (or other currency indicators), and no comma separators. All amounts are in US currency.

4. Multi-paged claim
    - Page Total: Do not put the total claim amount on any first or intermediate page
        i. The total must be placed on the last or final page of the multiple-paged claim. If the total is placed on each page, MaineCare will consider the page a stand-alone claim.
    - Fill out header information on each page with identical information. This will help ensure that the claim pages are kept together.
    - Other than Service Lines and Totals, only header information from page 1 will be used for actually processing the claim.
        i. Attachments (e.g., operative notes) for a multiple-page claim will be placed after the last page of the claim, and the attachment(s) will be secured with a paperclip.
    - Put page numbering for multi-page claims (in the format *page* of *total pages*) in the open area in the upper righthand area of the claim form.

5. Mailing Claims
    - Send or fax pre-treatment estimate requests and prior authorization requests to:

      Prior Authorization Unit
      MaineCare Services
      11 State House Station
      Augusta, ME 04333
      A fax number will be published closer to the Go-Live date.
    - Mail the completed Dental Claim Form including replacement or reversal claims to:

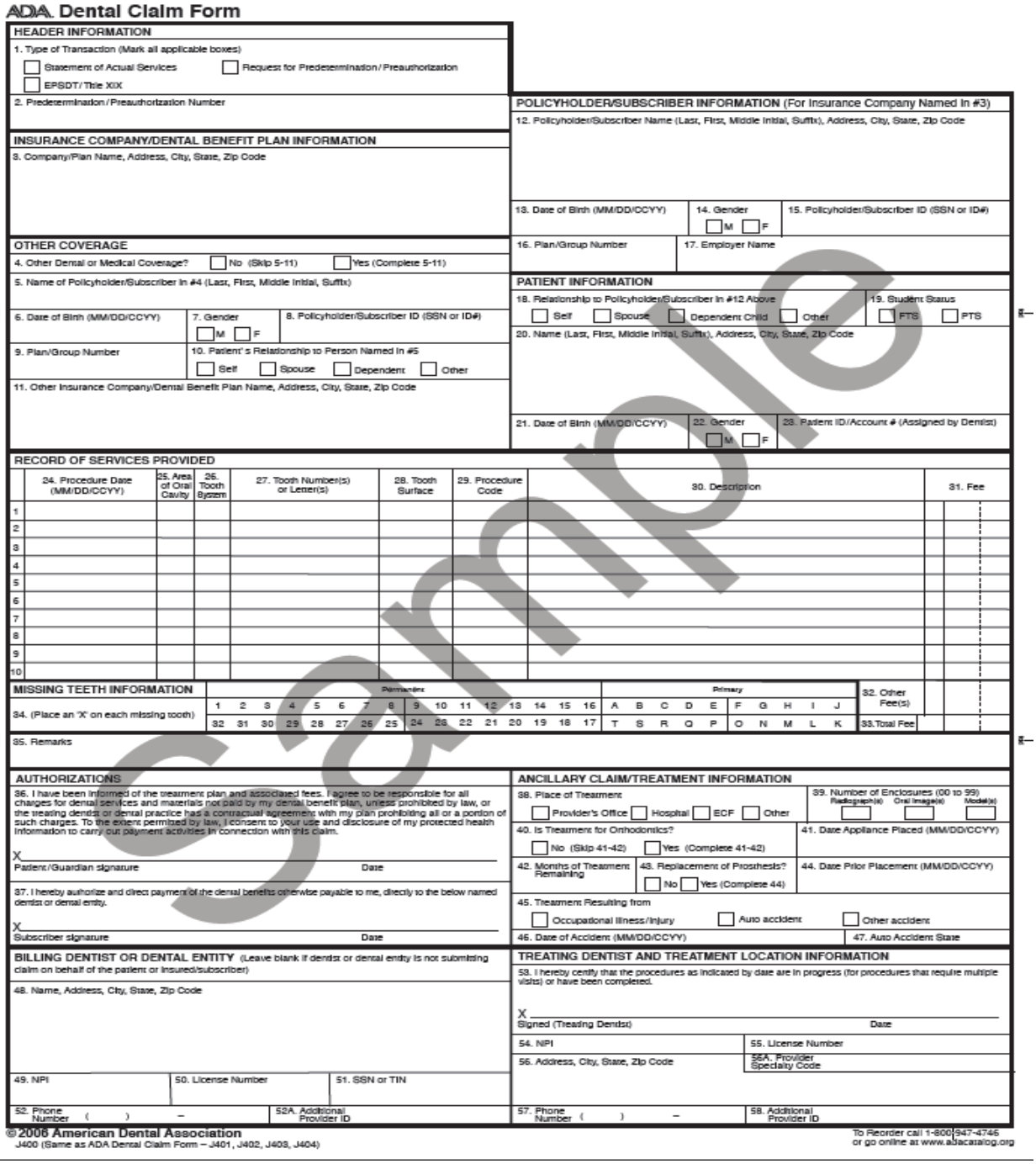
      MaineCare Claims Processing
      M-600
      Augusta, ME 04333

6. Attachments
    a. Attachments may be provided in any of the following ways:
        i. Attach paper attachment to a paper claim
        ii. Attachments may be uploaded through the Portal when submitting claims via direct data entry
        iii. Attachments may be uploaded through the Portal for claims previously submitted via EDI or paper by searching for the matching claim and uploading a scanned attachment
            1. Any paper attachments sent in later than the claim submission should reference the original claim ID via a cover sheet

7. Terminology

The ADA Dental form uses the term patient extensively to label boxes on the form. However, within this Billing Instructions Guide, the term patient may be used interchangeably with the term member used by MaineCare.

The ADA 2006 Dental Claim Form is shown below.



ADA Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX
2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee
35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X _____ Patient/Guardian signature _____ Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____ Subscriber signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)
48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) – | 52A. Additional Provider ID

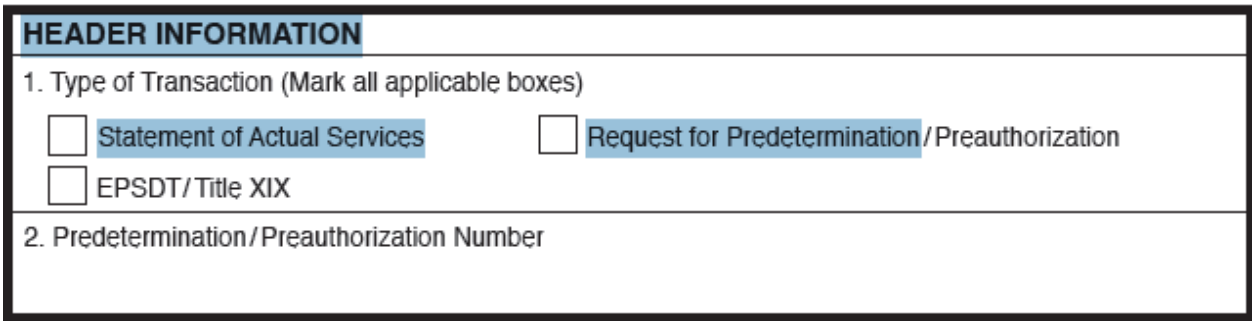
ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X _____ Signed (Treating Dentist) _____ Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56A. Provider Specialty Code
57. Phone Number ( ) – | 58. Additional Provider ID

2. Form Instructions

The form instructions will describe how each field will be filled out including whether the field is Required, Situational, Optional, or Not Used.

2.1 Header Information (Type of Transaction/PA)



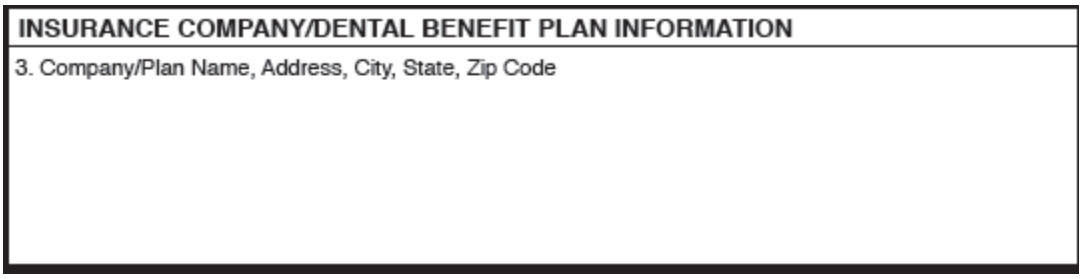
Box 1: Type of Transaction

- Required
  - Check the reason for the submission of the ADA form
    i. For Claims, put an X in the box next to the Statement of Actual Services
    ii. For PA's, put an X in the box next to the Request for Predetermination/Preauthorization; and submit a prior authorization letter or form only when the preauthorization item is checked
    iii. For EPSDT program services, put an X in the box next to the EPSDT option

Box 2: Predetermination/Preauthorization Number

- Situational
  - If MaineCare Services or another agency issued prior authorization for this procedure, enter the Prior Authorization number.
  - If this procedure does not need prior authorization, leave this box blank.

2.2 Insurance Company/Dental Benefit Plan Information



Box 3: Company/Plan Name, Address, City, State, Zip Code

- Optional.
  - MaineCare is assumed to be the Insurance Company.

2.3 Other Coverage

OTHER COVERAGE		
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

Box 4: Other Dental or Medical Coverage?

- Required
  - Check the Yes Box when the member has insurance coverage with any other company outside of MaineCare that relates to the services being performed.
    i. When the "yes" box is marked, items 5 through 11 in this section **are required**.
  - Check the "No" box whenever a member does not have coverage under any other dental or medical plan that relates to the services being performed.
    i. When the "no" box is marked, items 5 through 11 in this section are not to be completed.

Box 5: Name of Policyholder/Subscriber in #4

- Situational (required if "Yes" is checked in Box 4)
  - Enter last name, first name, middle initial and suffix. Include any punctuation that is in the policyholder/subscriber's name.
    i. Example: O'Neil, Susan J

Box 6: Date of Birth

- Situational (required if "Yes" is checked in Box 4)
  - Enter the date of birth of the person listed in Box 5
    i. Must be in MMDDCCYY format, e.g., 10011979

Box 7: Gender

- Situational (required if "Yes" is checked in Box 4)
  - Enter the gender of the person listed in Box 5
    i. Options M or F
       a. M-Male
       b. F-Female

Box 8: Policyholder/Subscriber ID (SSN or ID#)

- Situational (required if "Yes" is checked in Box 4)
  - Enter the ID or social security number of the individual listed in Box 5

Box 9: Plan/Group Number

- Situational (required if "Yes" is checked in Box 4)
  - Enter the group plan or policy number of the individual listed in Box 5

Box 10: Patient's Relationship to Person Named in #5

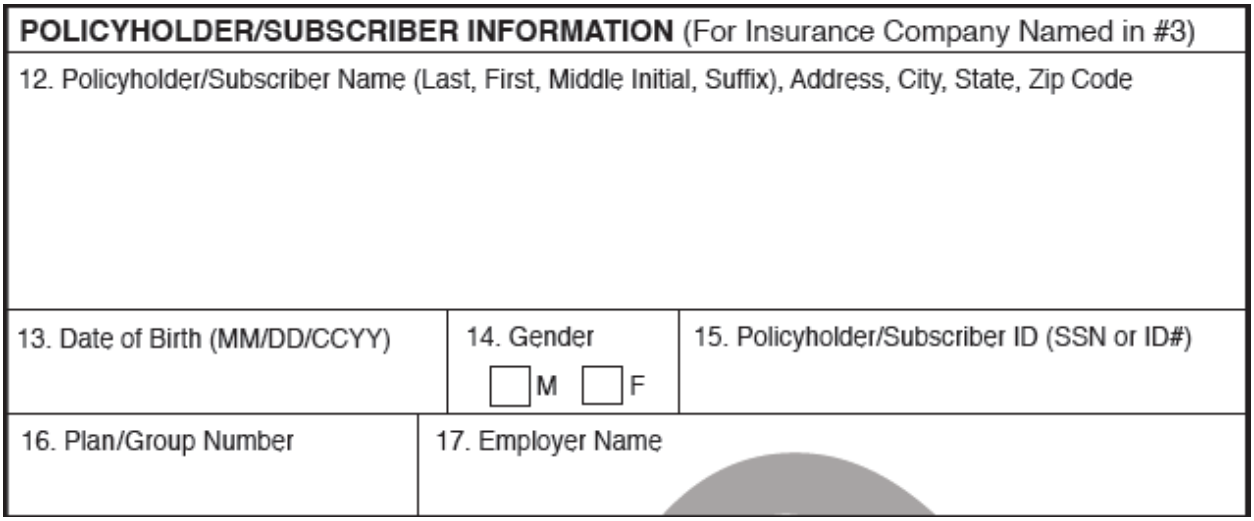
- Situational (required if "Yes" is checked in Box 4)
  - Indicate the patient's relationship to the insured named in Box 5
    i. Self
    ii. Spouse
    iii. Dependent
    iv. Other

Box 11: Other Insurance Company/Plan Name, Address, City, State, Zip Code

- Situational (required if "Yes" is checked in Box 4)
  - Enter the name, group number and address (including street, city, state and zip) of the additional payer when there is third party insurance coverage besides MaineCare

2.4 Policyholder/Subscriber Information

MaineCare is assumed to be the Insurance Company for Box #3.



POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

Box 12: Policy Holder/Subscriber Name

- Required
  - Enter the member's name exactly as it appears on the member's MaineCare eligibility card: last name, first name, and middle initial.
  - Enter the address of the MaineCare member

Box 13: Date of Birth

- Required
  - Enter member's date of birth
  - Must be in MMDDCCYY format, e.g., 10011979

Box 14: Gender

- Required
  - Options M or F

Box 15: Policyholder/Subscriber ID

- Required
  - Enter member's MaineCare Identification number
  - Never enter the member's SSN in box 15; always use the MaineCare ID.
  - To verify a member's MaineCare eligibility
    i. Use MyHealth PAS online portal; or
    ii. Submit a 270 EDI Request for Eligibility verification request
    iii. Use the medical eligibility swipe card system, or the Interactive Voice Response system (IVR).

Box 16: Plan Group Number

- Not Used

Box 17: Employer Name

- Not Used

2.5 Patient Information

PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other		19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

Box 18: Relationship to Policyholder/Subscriber in #12 Above

- Not Used

Box 19: Student Status

- Not Used

Box 20: Name

- Not Used

Box 21: Date of Birth

- Not Used

Box 22: Gender

- Not Used

Box 23: Patient ID/Account

- Required
  - Use your internal numbering or accounting system identifier in this location
  - Field may be alpha numeric
    i. Examples:
      - 123456
      - Smith, John
      - Smit1234

    i.

2.6 Record of Services Provided: Box 24 through 31: Required (unless otherwise noted)

- Repeat Boxes 24-31 for any additional services/procedures rendered, up to a total of 10 lines per claim form

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

32. Other Fee(s)	
33.Total Fee	

Box 24: Procedure Date

- Required
  - Enter the date of the service
  - Must be in MMDDCCYY format, e.g., 04012010

Box 25: Area of Oral Cavity

- Situational (required if procedure is related to the oral cavity)
  - Use this box to report the area of the oral cavity when the procedure is related to an oral cavity, e.g. periodontal sealing
  - Valid values are:

Code	Area
00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant

20 Upper left quadrant
30 Lower left quadrant
40 Lower right quadrant

Box 26: Tooth System

- Not Used

Box 27: Tooth Number(s) or Letter(s)

- Situational (required if procedure directly involves a tooth)
  - Must be no more than two (2) characters
  - Enter the tooth number (1–32 for permanent teeth) or the tooth letter (A–T for primary teeth)
    i. NOTE: For tooth numbers 1–9, do not put a zero before the tooth number
  - For supernumerary tooth designation, use the following:
    i. Permanent dentition: Supernumerary teeth are identified by the numbers 51–82 (add 50 to each tooth number)
       - Example: tooth 32 would be supernumerary tooth 82
    ii. Primary dentition: For supernumerary teeth (A–T), place the letter S after the letter of the primary tooth
       - Examples: tooth A would be AS. Tooth Q would be QS

Box 28: Tooth Surface

- Situational (required if procedure directly involves one or more tooth surfaces (e.g. restorations)
  - Enter the appropriate letter indicating the surface of the tooth that was restored:

O: occlusal
M: mesial
D: distal
B: buccal
L: lingual
F: facial
I: incisal

Box 29: Procedure Code

- Required
  - Enter the applicable CDT procedure code
  - Must be five (5) characters beginning with a "D"

Box 30: Description

- Optional
  - Enter description of procedure according to CDT guidelines
  - **Modifiers are not allowed on the ADA2006 form**

Box 31: Fee

- Required
  - Enter your fee
  - Must be in a valid currency format: dd.cc, e.g., 24.00. Dollar signs and commas (thousands separator) may not be entered.

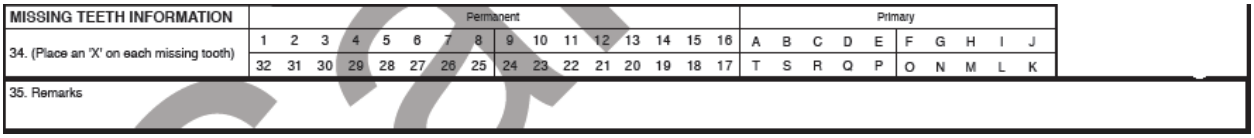
Box 32: Other Fee(s)

- Situational (required if billing after other insurance, or if the member has spenddown)
  - If billing after other insurance the EOB must be attached.
  - In a spenddown situation, enter the insurance payment in this box, and/or enter spenddown amount here. Attach spenddown letter

Box 33: Total fee

- Required
  - Enter the total charge on the last Page of a multi page claim
    - i. Claims with totals on each page will be considered as individual claims
  - Must equal the total of Box 31 minus Box 32 for the final page of a claim
  - Must be in a valid currency format, dd.cc, e.g., 24.00

2.7 Missing Teeth Information & Remarks



MISSING TEETH INFORMATION	Permanent																Primary									
34. (Place an 'X' on each missing tooth)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K
35. Remarks																										

Box 34: Missing Teeth Information

- Situational (Required if the Procedure is related to Periodontal, Prosthodontic, whether fixed or removable, or Implant Services)
  - Place an X on the number or letter of each corresponding missing tooth

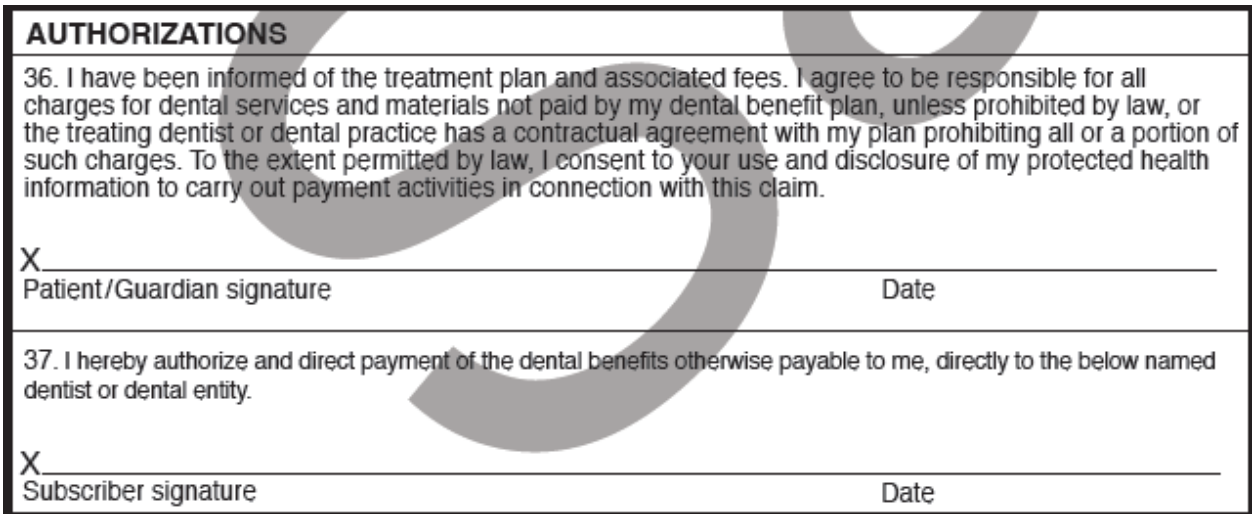
Box 35: Remarks (Left-justified)

- Situational (required if provider has multiple service locations)
  - The service location ID is needed ***if*** the provider has enrolled with more than one service location within MaineCare.
  - Service Location ID: 10 Digit NPI plus the 3 digit servicing location identifier of -001, 002, etc.(e.g., 1234567890-003)

Box 35: Remarks (Right-justified)

- Situational (required when submitting an adjustment claim)
  - If this is an adjustment claim, enter one of the following on the right hand side of Box 35, followed by the claim ID from the Remittance Advice (RA)
    - 7 – for Replacement of a previous claim
    - 8 – for Reversal or Cancel

2.8 Authorizations



Box 36: Patient/Guardian signature

- Not Used

Box 37: Subscriber signature

- Not Used

2.9 Ancillary Claim/Treatment Information

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other		39. Number of Enclosures (00 to 99) Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident		
46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State

Box 38: Place of Treatment

- Required
  - Check the applicable box
  - Must have one box checked
  - Select ECF (Extended Care Facility) if the service was in a Nursing Facility, Boarding Home, ICF/MR, Adult Family Home, or Private Non-Medical Institution.

Box 39: Number of enclosures

- Situational (required for Prior Authorization Requests Only)
  - Utilize this box to note the number of attachments enclosed with the ADA 2006 form when used to generate a Prior Authorization request
- **NOT REQUIRED for Claims**

Box 40: Is the treatment for orthodontics?

- Required
  - Check Yes or No
  - Must have one box checked

Box 41: Date Appliance Placed

- Situational (Required if Box 40 is Yes)
  - Enter the date the appliance was applied in MMDDCCYY format, e.g., 04192010

Box 42: Months of Treatment Remaining

- Situational (Required if Box 40 is Yes)
  - Enter total months of treatment remaining
  - Must be a number and 2 characters or less

Box 43: Replacement of Prosthesis

- Not Used

Box 44: Date Prior Placement

- Not Used

Box 45: Treatment Resulting from

- Situational (required if treatment for accident or occupational harm)
  - Check appropriate box if the treatment is the result of an occupational illness/injury, auto accident, or other accident
    i. If box is checked, give a short description of the illness or injury

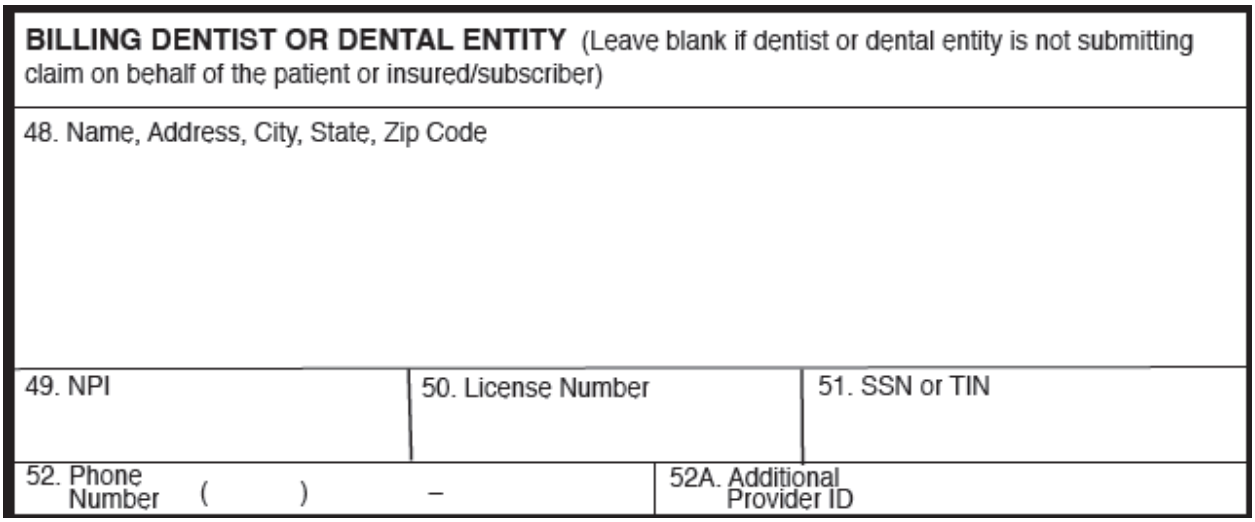
Box 46: Date of Accident

- Situational (required if treatment for accident or occupational harm)
  - If any box in 45 is checked enter the date of occupational illness/injury, auto, or other accident in MMDDCCYY format, e.g., 10012009

Box 47: Auto Accident State

- Situational (required if treatment needed for accident or occupational harm)
  - If Auto Accident box in 45 is checked, enter the two letter State abbreviation where the accident took place.
  - State abbreviations can be obtained at http://www.usps.com/ncsc/lookups/abbreviations.html.

2.10 Billing Dentist or Dental Entity



Box 48: Name, Address, City, State, Zip Code

- Required
  - Enter the name of the billing dentist or group (as enrolled with MIHMS)
    i. The provider name entered in this box is the provider name that services will be reimbursed to and should match the information supplied to AdvantageME
  - Enter the address of the billing dentist or group

Box 49: NPI

- Required

- Enter the 10-digit billing provider's NPI (National Provider Identifier).
  i. This is also called the Pay To NPI

Box 50: License number

- Optional
  - Enter the license number of the dentist or other dental professional who provided the service

Box 51: Social Security Number (SSN) or Tax Identification Number (TIN)

- Required
  - Enter the TAX ID number matching the Pay To NPI

Box 52: Phone Number

- Optional
  - Enter phone number for billing provider

Box 52a: Additional Provider ID

- Not Used

2.11 Treating Dentist and Treatment Location Information

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X _____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number ( ) –	58. Additional Provider ID

Box 53: Signature or name of treating dentist and date

- Required
  - Enter the provider's name
  - The signature may be typed or stamped. An authorized person may sign on behalf of the treating dentist. The name must be the name of an actual person
  - Do not use "signature on file"
  - Enter the month, day and year this claim form was completed using the eight-digit format MMDDCCYY, e.g. 04232010

Box 54: NPI

- Situational (required if a rendering provider performed the services)
  - Enter the 10-digit performing (rendering) provider's NPI (National Provider Identifier)

Box 55: License Number (of treating dentist)

- Optional

Box 56: Address, City, State, Zip Code

- Optional
  - Enter address for the treating provider

Box 56a: Provider specialty code

- Optional
  - Enter the Specialty code associated with the NPI in Box 54

Box 57: Phone Number

- Optional

Box 58: Additional Provider ID

- Not Used

2.12 Quick Reference

Section of Claim Form	Required	Situational	Optional / Not Used
Box 1: Type of Transaction	Required		
Box 2: Predetermination/Preauthorization Number		Situational	
Box 3: Company/Plan Name, Address, City, State, Zip Code			Optional
Box 4: Other Dental or Medical Coverage?	Required		
Box 5: Name of Policyholder/Subscriber in #4		Situational	
Box 6: Date of Birth		Situational	
Box 7: Gender		Situational	
Box 8: Policyholder/Subscriber ID (SSN# or ID)		Situational	
Box 9: Plan/Group Number		Situational	
Box 10: Patient's Relationship to Person Named in #5		Situational	
Box 11: Other Insurance Company/Plan Name, Address, City, State, Zip Code		Situational	
Box 12: Policy Holder/Subscriber Name	Required		
Box 13: Date of Birth	Required		
Box 14: Gender	Required		
Box 15: Policyholder/Subscriber ID	Required		
Box 16: Plan/Group Number			Not Used

Section of Claim Form	Required	Situational	Optional / Not Used
Box 17: Employer Name			Not Used
Box 18: Relationship to Policyholder/Subscriber in #12 Above			Not Used
Box 19: Student Status			Not Used
Box 20: Name			Not Used
Box 21: Date of Birth			Not Used
Date 22: Gender			Not Used
Box 23: Patient ID/Account #	Required		
Box 24: Procedure Date	Required		
Box 25: Area of Oral Cavity		Situational	
Box 26: Tooth System			Not Used
Box 27: Tooth Number(s) or Letter(s)		Situational	
Box 28: Tooth Surface		Situational	
Box 29: Procedure Code	Required		
Box 30: Description			Optional
Box 31: Fee	Required		
Box 32: Other Fee(s)		Situational	
Box 33: Total fee	Required		
Box 34: Missing Teeth		Situational	
Box 35: Remarks (Left-justified)		Situational	
Box 35: Remarks (Right-justified)		Situational	
Box 36: Patient/Guardian Signature			Not Used
Box 37: Subscriber Signature			Not Used
Box 38: Place of Treatment	Required		
Box 39: Number of enclosures		Situational	
Box 40: Is the treatment for orthodontics?	Required		
Box 41: Date Appliance Placed		Situational	
Box 42: Months of Treatment Remaining		Situational	
Box 43: Replacement of Prosthesis?			Not Used
Box 44: Date Prior Placement			Not Used

Section of Claim Form	Required	Situational	Optional / Not Used
Box 45: Treatment Resulting from		Situational	
Box 46: Date of Accident		Situational	
Box 47: Auto Accident State		Situational	
Box 48: Name, Address, City State, Zip Code	Required		
Box 49: NPI	Required		
Box 50: License number			Optional
Box 51: Social Security Number (SSN) or Tax Identification Number (TIN)	Required		
Box 52: Phone Number			Optional
Box 52a: Additional Provider ID			Not Used
Box 53: Signature or name of treating dentist and date	Required		
Box 54: NPI		Situational	
Box 55: License Number (of treating dentist)			Optional
Box 56: Address, City, State, Zip Code			Optional
Box 56a: Provide specialty code			Optional
Box 57: Phone Number			Optional
Box 58: Additional Provider ID			Not Used

Legend

Required - This item must be completed with the proper information as specified.

Situational - This item must be completed with the proper information, if the stated triggering event applies.

Optional - This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information specified by ADA guidelines, or these instructions, if they differ.

Not Used - This item need not be completed as MaineCare/MIHMS never looks at this field.